

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 26855</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 12/04/09 and finalized on 12/04/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>Complaint #NV00023771 was substantiated with deficiencies cited. (See Tags S0145, S0146, S0152, S0310)</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following deficiencies were identified.</p>	S 000		
S 145 SS=G	<p>NAC 449.332 Discharge Planning</p> <p>3. A hospital shall, at the earliest possible stage of hospitalization, identify each patient who is likely to suffer adverse health consequences upon discharge if the patient does not receive adequate discharge planning. The hospital shall</p>	S 145		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 145	<p>Continued From page 1</p> <p>provide for an evaluation of the needs related to discharge planning of each patient so identified. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and discharge policy and procedure review, the facility failed to ensure a patient with a diagnoses of dementia and cognitive impairment who was confused and disorientated received a safe discharge plan and protective supervision and was discharged and transported into the care and custody of a responsible party. (Patient #1)</p> <p>Findings include:</p> <p>Patient #1 was a 84 year old female who was transported by ambulance from a memory care facility and admitted to the facilities emergency room on 12/02/09 with a chief complaint of vomiting and diarrhea. The patients diagnoses included dementia with cognitive impairment.</p> <p>On 12/04/09 at 9:30 AM, the Chief Nurse reported Patient #1 was treated in the emergency room for vomiting and diarrhea and kept overnight. The patients nurse documented in the emergency room record that the patient had a history of dementia. The Chief Nurse acknowledged the patients nurse failed to follow the facilities safe discharge policy and procedure by not notifying the memory care facility where the patient resided regarding the patients pending discharge and failed to provide protective supervision by not discharging the patient to a responsible party or arranging transportation for the patient back to the memory care facility. The Chief Nurse reported the patients nurse escorted the patient to the emergency waiting room lobby and released the patient unsupervised to the street. The Chief Nurse reported the incident was</p>	S 145			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 145	<p>Continued From page 2</p> <p>discovered after the administrator of the memory care facility called to check on the patients status and discovered the patient had been discharged without protective supervision. The Chief Nurse reported facility security and police conducted a missing persons search. The patient was located by police one and a half hours later at the intersection of Desert Inn and Topaz banging on a window of a business asking for help.</p> <p>On 12/04/09 at 10:30 AM the Emergency Room Clinical Supervisor reported on 12/03/09 at 7:20 AM, during the change of shift a representative from a memory care facility called to inquire about the status of Patient #1. The Clinical Supervisor reported she reviewed the patients emergency room record and discovered documented in the initial assessment that the patient had a history of dementia and had been discharged by RN #1 at 6:25 AM. The Clinical Supervisor acknowledged RN #1 failed to ensure the patient was discharged to a responsible party and failed to facilitate transportation for the patient back to the memory care facility where the patient resided. The Clinical Supervisor reported the facilities discharge policy included consultation with the emergency room charge nurse on all elderly patients and patients who were diagnosed with Alzheimer's dementia or cognitive impairment to ensure the discharge process was conducted in a safe manner. The Clinical Supervisor confirmed RN #1 failed to consult the charge nurse or any other emergency room staff member prior to the patients discharge in violation of facility policy.</p> <p>Ambulance report dated 12/02/09 dated 10:53PM, indicated the patient had a diagnoses that included dementia.</p>	S 145		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 145	<p>Continued From page 3</p> <p>Emergency Room Nursing Record dated 12/02/09 at 11:30 PM, indicated the patient arrived at the facility by ambulance with a chief complaint of diarrhea for the past 2 days. The patients past medical history included dementia. The patient's medications included Aricept used to treat Alzheimer's disease.</p> <p>Nursing Note dated 12/03/09 at 6:25 AM, indicated the patient was discharged per MD order. "The patient was discharged home. Verbal written instructions were given to the patient who verbalized understanding. The depart time from the facility was 6:25 AM. The mode was walking."</p> <p>The patients Treatment Authorization form dated 12/02/09 documented the patient could not sign because the patient had dementia.</p> <p>The patients Consent to Treatment and Conditions of Admission dated 12/02/09 documented the patient was unable to sign due to dementia.</p> <p>A Patient Self Determination record dated 12/02/09 documented the patient was incapable of answering questions concerning advance directive, living will or durable power of attorney because the patient had dementia.</p> <p>Medication Reconciliation and Physician Order Form dated 12/03/09 and filled out by RN #1 documented the patient was unable to recall what home medications she was taking.</p> <p>Discharge Instructions dated 12/03/09 were signed by the patient and RN #1.</p> <p>The Facility Emergency Services Discharge Policy last revised 08/09 included discharge</p>	S 145			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 145	<p>Continued From page 4</p> <p>instructions should be given to a friend, relative or guardian if the patient is intoxicated, not able to understand or hear the instructions.</p> <p>Facility Transfer of Stabilized Emergency Department Patient to Other Facilities Policy last revised 08/08 included the following:</p> <p>1. "A Transfer Log will be maintained of all patients requiring transfer to another facility. The Charge Nurse must review all transfers prior to a patient's departure to assure adherence to all requirements and appropriate documentation in the medical record."</p> <p>2. "Report will be called by the nurse caring for the patient. Name and title of person accepting report will be documented in the medical record."</p> <p>Facility Patient Transfer to Extended Care Facility, Skilled Nursing Facility and Rehabilitation Facility Policy last revised 02/07 included the following:</p> <p>1. "A copy of the patients transfer form will be provided to the receiving facility and a copy will be maintained on the chart."</p> <p>2. "Patient transportation is arranged through Case Management Department. Family will be notified of all transfer arrangements."</p> <p>Severity: 3 Scope: 1</p> <p>Complaint # 23771</p>	S 145			
S 146 SS=D	<p>NAC 449.332 Discharge Planning</p> <p>4. An evaluation of the needs of a patient relating to discharge planning must include, without</p>	S 146			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 146	Continued From page 5 limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the facility failed to ensure a patient diagnosed with dementia and cognitive impairment who was confused and disorientated was provided with a safe discharge plan that included an evaluation of the patients capacity for self care and appropriate placement after discharge. (Patient #1) Severity: 2 Scope: 1 Complaint # 23771	S 146		
S 152 SS=D	NAC 449.332 Discharge Planning 10. The discharge plan must be discussed with the patient or the person acting on behalf of the patient. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the facility failed to insure the discharge plan of a patient diagnosed with dementia and cognitive impairment was discussed with the patients conservator and the administrator of the memory care facility where the patient lived, prior to the patients discharge. (Patient #1) Severity: 2 Scope: 1	S 152		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS641HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2009
NAME OF PROVIDER OR SUPPLIER DESERT SPRINGS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 152	Continued From page 6	S 152		
	Complaint # 23771			
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Surveyor: 26855 Based on interview, record review and document review the facilities emergency room nursing staff failed to ensure the needs of a confused and disorientated patient diagnosed with dementia and cognitive impairment was appropriately and continually assessed in order to prevent an unsafe discharge. (Patient #1) Severity: 2 Scope: 1 Complaint # 23771	S 310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.